# Indian Health Service

## Expansion of the Community Health Aide Program: Building on the Successful Healthcare Delivery of Alaska

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# Learning Objectives

- Learners will develop an understanding of the CHAP and its program structure.
- Learners will be able to identify the three (3) provider disciplines in the CHAP.
- Learners will develop an understanding of the basic infrastructure needs for the CHAP, including the challenges inherent to the collaboration between Tribal and Federal systems.
- Learners will understand components of CHAP that are associated with the business and information technology systems.
- Learners will understand how to engage and collaborate with CHAP to grow the program nationally.

# Overview

- Introduction of Panelists
- History of CHAP
- Community Health Aide (CHA) Development
- Dental Health Aide (DHA) Development
- Behavioral Health Aide (BHA) Development
- CHAP Business & Information Technology Systems

# Historical Development of CHAP

**1950-1960s-** CHAP begins in response to a TB outbreak and the chemotherapy aide is created to mobilize the village medical team

**1968-** Formal Training & federal funding formalizing the program

**1975-** Indian Self-Determination and Education Assistance Act (PL 93-638)

**1998-** Alaska CHAPCB authority through the Snyder Act & IHCIA

**2005-** First Cohort of dental health aides certified formally adding “DHA” to Alaska CHAP

**2009-** First cohort of behavioral health aides certified formally adding “BHA” to Alaska CHAP


PRACTICE
SUPERVISION
TRAINING
CERTIFICATION
ADMINISTRATIVE OVERSIGHT

# Community Health Aide Program

The Community Health Aide Program (CHAP) includes three (3) different health aide provider types which each include a tiered level practice.

| Community Health Aide | Dental Health Aide | Behavioral Health Aide |
|---|---|---|
| • Community Health Aide I<br>• Community Health Aide II<br>• Community Health Aide III<br>• Community Health Aide IV<br>• Community Health Aide Practitioner | • Primary Dental Health Aide I and II<br>• Expanded Function Dental Health Aide I and II<br>• Dental Health Aide Hygienist<br>• Dental Health Aide Therapist | • Behavioral Health Aide I<br>• Behavioral Health Aide II<br>• Behavioral Health Aide III<br>• Behavioral Health Aide Practitioner |

# Community Health Aide (CHA)

*THE PRIMARY & EMERGENT CARE PARAPROFESSIONAL*

# Role of Community Health Aides: CHAs

- Community Health Aides (CHAs) are the frontline healthcare providers within the CHAP.
- They undergo rigorous and comprehensive training to offer a diverse range of essential medical services.
- CHAs are equipped to provide basic medical care, administer first aid, handle emergency treatments, conduct health education sessions, and more.

# CHA: Impact and Success

- The Community Health Aide Program has had a profound impact on healthcare access and outcomes in remote and underserved regions.
- CHAs serve as critical links between their communities and medical facilities, enabling timely and culturally sensitive care.
- As trusted healthcare advocates, CHAs promote trust, build cultural understanding, and foster better health equity within their communities.

# CHA: Integration of Technology

- To enhance healthcare delivery, the CHAP has adopted telemedicine and telehealth services.
- CHAs can access remote consultations with off-site medical professionals, ensuring timely access to specialized care.
- The integration of technology has streamlined healthcare services, making them more efficient and effective.

# CHA: Expansion Beyond Alaska

- Community-based approach and cultural competency proven highly effective in addressing healthcare disparities in diverse settings.
- Emphasis on cultural understanding strengthens trust and acceptance in implementing the CHAP.
- Flexibility and replicability of core principles allow adaptation to unique cultural contexts.
- Community engagement fosters ownership and pride in the program's success.

# CHA: Future Outlook

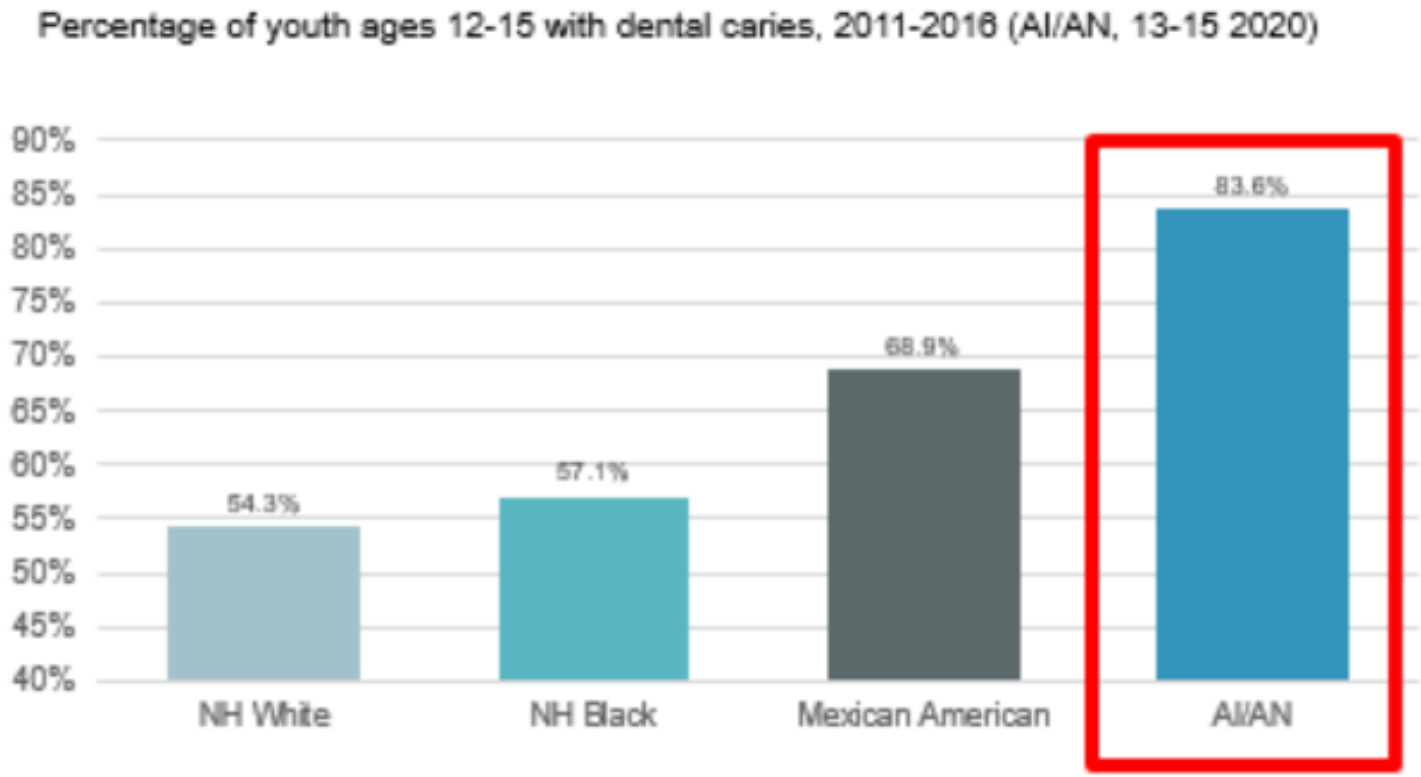
- Continued evolution and improvement of CHAP.
- Potential for further expansion to address healthcare disparities in other regions.
- Long-lasting impact on healthcare delivery and health equity.

# Dental Health Aide (DHA)

*COMMUNITY BASED ORAL HEALTHCARE*

# Oral Health Disparities

## Oral Health Disparities: 13-15 Year-Olds

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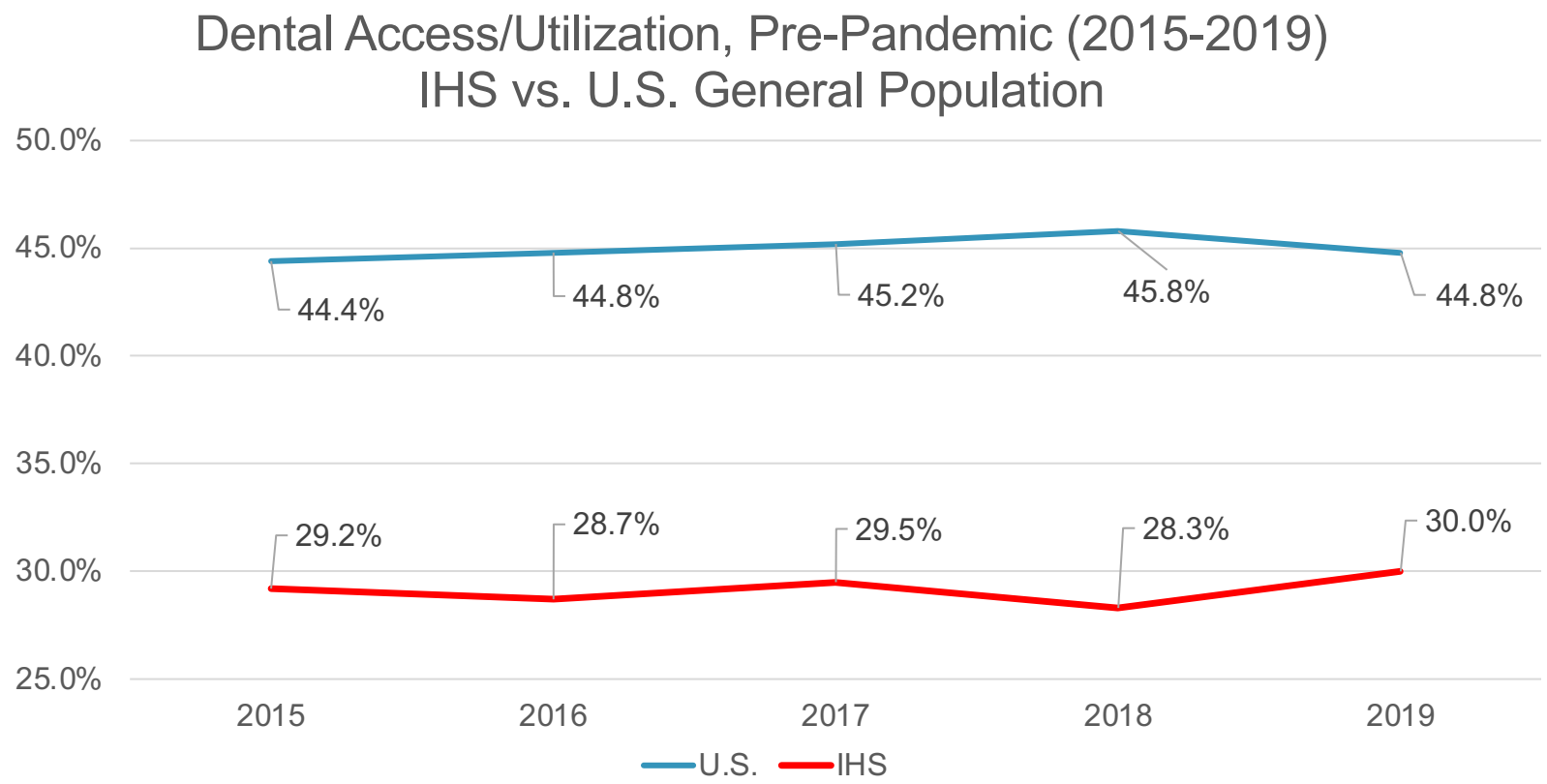
https://www.ihs.gov/doh/documents/surveillance/IHS_Data_Brief_Oral_Health_13-15_Year_Old_Follow-Up_to_2013_Survey.pdf

# Access to Dental Care

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Manski, R., Rohde, F., Ricks T., and Chalmers, N. Trends in the Number and Percentage of the Population with Any Dental or Medical Visits, 2019. Statistical Brief #544. October 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://meps.ahrq.gov/data_files/publications/st544/stat544.pdf

# Primary Dental Health Aides (PDHA) I and II

## PDHA I

- Health Educator
- Fluoride varnish applications
- Nutritional counseling
- Oral hygiene instruction

## PDHA II

- Sealants
- Atraumatic restorative treatment
- Dental radiology
- Dental Assisting

# Dental Health Aide Types

- Primary Dental Health Aide I & II
- Expanded Function Dental Health Aide I & II
- Dental Health Aide Hygienist
- Dental Health Aide Therapist

# Expanded Function Dental Health Aide (EFDHA) I and II

## EFDHA I

- Basic restorations
- Basic supra-gingival dental cleanings

## EFDHA II

- Advanced restorations

# Dental Health Aide Hygienist (DHAH)

- Allows a licensed dental hygienist, who has received additional and appropriate  training, to provide anesthesia without a dentist being physically present in the clinic

- Offers patients with more advanced gum disease the ability to receive treatment in their home community during times when a dentist is not present in the community

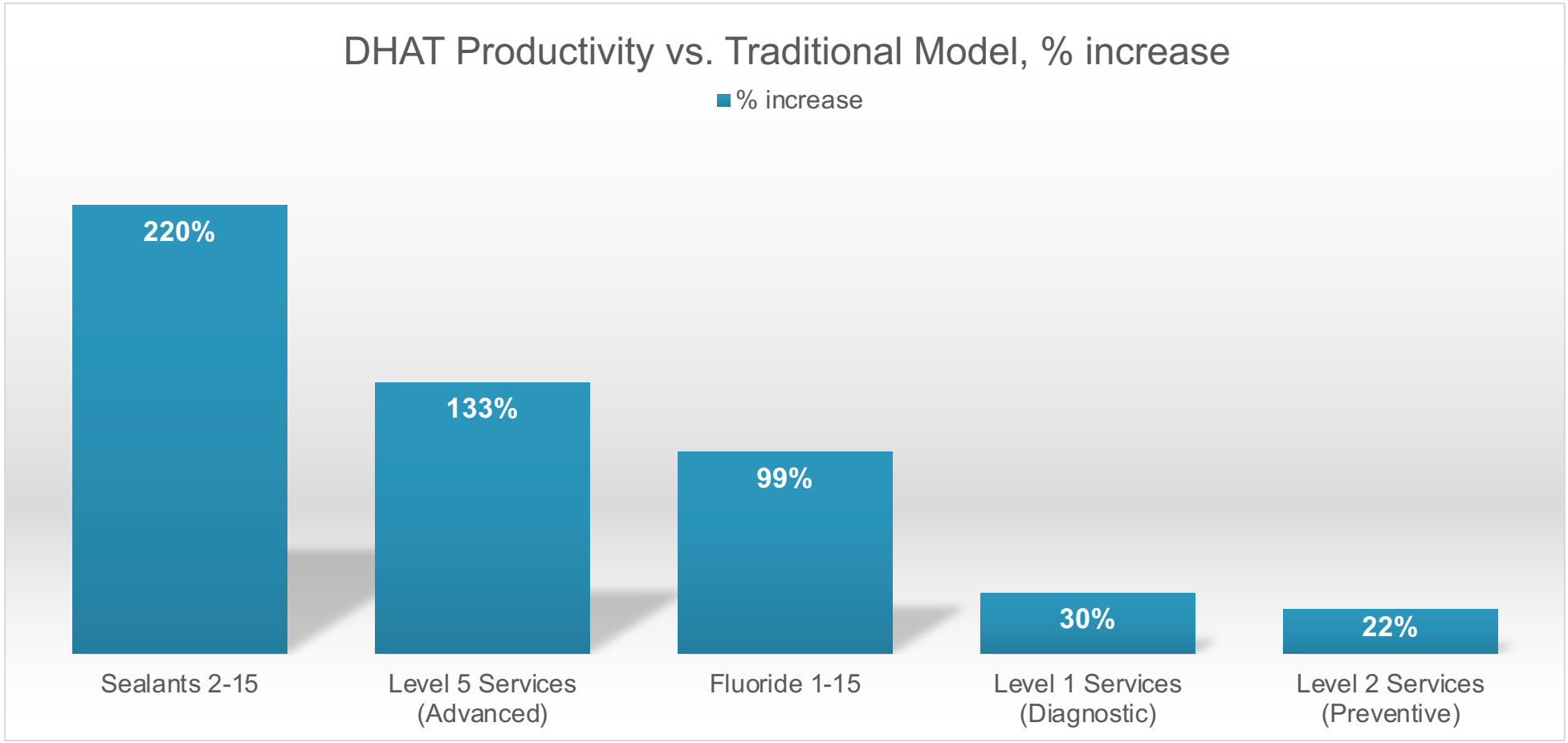
# Dental Health Aide Therapist (DHAT)

- Requires the highest level of education and training of the Dental Health Aides

- Three academic years of education and training in dental disease prevention, restorative, relatively non-complicated extractions and basic dental treatment skills. Training can be accomplished in *two academic years, via compressed curriculum*.

- Nationally, outside of the IHS, DHATs are known as "**Dental Therapists**"

# Clinical Efficiency is Boosted with Dental Therapy




*Done in collaboration with the Johns Hopkins Bloomberg School of Public Health

# Behavioral Health Aide (BHA)

*MENTAL HEALTH AND SUBSTANCE ABUSE*

# Behavioral Health Status

- Highest rates of suicide of any minority group within the U.S. and rates are increasing since 2003, as well as high rates of substance use disorder of both illicit drugs and alcohol use
- From 2016 to 2020, they experienced alcohol-related deaths at significantly higher rates (51.9/100,000) than the rest of the U.S. population (11.7/100,000 ) 1
- Highest prevalence of methamphetamine use, as well as methamphetamine use disorder, methamphetamine injection, and with significant increases in methamphetamine overdose 2
- In 2019 and 2020, drug overdose death rates were highest for non-Hispanic American Indian and Alaska Native people at 30.5 and 42.5 per 100,000, respectively
- From 2019-2020, the American Indian and Alaska Native overdose death rates increased by 39%

# Role of the Behavioral Health Aide

- Behavioral Health Aide/Practitioners use a combination of Western and traditional based practices to provide behavioral health prevention treatment and recovery services to our beneficiaries.
- BHAs are counselors, health educators, and advocates for patients
- BHAs find a balance between the cultural needs of a client and providing specialized treatment to the client.
- Was added to the CHAP in 2009 and modeled after the Community Health Aides

# Certification Requirements

- **BHA Level One:** 1000 work hours under the direct supervision of a licensed BH professional and 100 hours of clinical practicum.
- **BHA Level Two:** 1000 work hours under the direct supervision of a licensed BH professional and 100 hours of clinical practicum.
- **BHA Level Three:** 4000 work hours under the direct supervision of a licensed BH professional and 100 hours of clinical practicum.
- **BHP:** 6000 work hours under the direct supervision of a licensed BH professional and 100 hours of clinical practicum.

# Course Requirements

**BHA-I:** Community Needs Assessment; Screening, Intake, Referral, Crisis Management, Case Management, Orientation to Services, Life Skills Development, Psycho education, Individual and Group Interventions

**BHA-II:** BHA I and Substance Abuse Disorder Assessment, SUD diagnosis, SUD treatment planning, SUD Treatment Implementation, Community Readiness Assessment, Individual, Group Family Counseling

**BHA-III:** BHA-I &II and Treatment Planning and Implementation for Co-Occurring Disorders, Child/Youth Services, Clinical Case review, Quality Assurance Case Review

**BHA Practitioner:** BHA I, II, III and BHA Mentoring, child centered interventions

# Billing for CHAP

- The program should become self-sustaining by billing for services, just like any other provider without requiring CHAPs bill under an existing licensed provider's license
- In order to bill Medicaid, State Plan Amendments (SPAs) must be passed
- Medicare would be a separate matter with potential for multiple medical billing opportunities, including chronic care management. This authorization is being pursued.
- Alaska is the only State that currently includes CHAP services as a billable service
- Oregon and Washington have submitted SPAs for CHAP at this time
  - ✓Some providers scopes of work may fit well under existing provider types which may already be billable
  - ✓If not able to fit under existing provider types, new provider codes may have to be developed

# CHAP and Technology

- CHAP implementation may be variable from community to community, based upon local needs
- CHAPs will need to have portable access to their electronic health aide manuals and EHR access
- Need to be able to communicate through EHR with other providers and pharmacy quickly
- May need to request medications for patients, use pick-point, pharmacies or other means
- Telehealth usage needs to be explored more, but there are ample opportunities to put it to good use through CHAP
- Developing opportunities for real-world data and quality assessment with the shared EHR documentation between licensed provider and CHAP

# GIPRA Measures and Program Success Metrics Data Collection

- Data sovereignty is **always** respected
- Data influences change
- CHAP is in the spotlight and showing program impacts in solid numbers will be key
- Multiple IT systems are used by tribes and CHAP is meant to be tribally-run
- How do we build the linkages to securely collect the program data to support CHAP efficacy?
- Partnership throughout the program must be very strong

# Indian Health Service

# EHR Modernization
# WRAP Update
# Business Process Modeling

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# EHR Modernization
# What Can We Do Now?

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HIT MODERNIZATION & INNOVATION

# Health IT Modernization
## December 2022 CIO Newsletter – Jeanette Kompkoff

- We've all been hearing a lot about health information technology (IT) modernization and the coming replacement of the Resource and Patient Management System (RPMS), and some very reasonable questions to ask include:
- "When is all this going to happen?" **and**
- "What do we need to do to get ready?"
- In this article, we'll focus on that second question.
- Actual go-live of the first few sites is **more than two years** away, but there are things that our organizations can do to prepare what is coming.

# Health IT Modernization
# What We Can Do Now?

**Prioritize** your People – Address staffing concerns
**Identify** change champions – **i.e.** Superusers, Package Owners
**Catch up** on any billing, coding & accounts receivable
**Engage** with Workflow Research & Alignment Plan (WRAP)
**Optimize** RPMS EHR as delineated through the WRAP Best Practice/Future State Business Process Modeling (BPMN) Workflows & IHS Program Initiatives
**E.g.** Telehealth, STI/Syphilis, ACT, ASQ, HOPE, EHR Component Functionality, PAMPI, 4DW
**Keep** RPMS up to date with patches
**Adhere** to life cycle management best practices for all technologies
**Leverage** Health Information Technology (HIT) to improve safety and patient outcomes
**E.g.** Clinic BCMA, Outpatient ADC Profiling, Smart Pumps
**Routinely** monitor RPMS
**Ensure** system administration process & backups are performed

# Standardization - EHR Modernization https://www.ihs.gov/hit/

- **Community Health Aide Program (CHAP)**
- **CHIT 2015 (Certified Health Information Technology)**
- **HL7 Data Transmission**
- **COVID-19 Vaccine CDC-IHS Data Management**
- **21st Century Cures Act (21 CCA – Cures Bundle)**
- **IHS Four Directions Warehouse (4DW)– PAMPI+ and Migration of Data**

  **Problems**
  **Allergies**
  **Medications**
  **Procedures**
  **Immunizations**
  **Encounters**

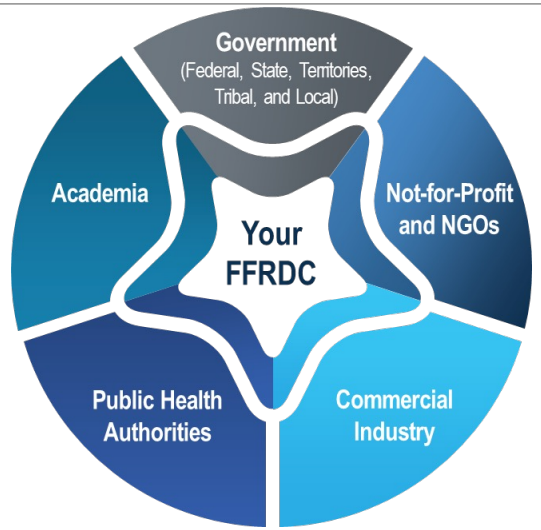
# EHR Business Process Modeling

RYAN LUGINBUHL, MD

AMANDA CRAY, CLSSGB

WEDNESDAY, AUGUST 23, 2023

# Federally Funded Research & Development Center (FFRDC)




## Key Attributes

- Created by government — a federal entity
- Addresses key challenges of considerable complexity
- Analyzes technical questions with a high degree of objectivity
- Provides innovative and cost-effective solutions to government problems
- Does not compete with industry or develop commercial products
- Can perform functions that are "close to inherently governmental"
- Independent operator enables broad stakeholder engagement

[Federal Acquisition Regulation 35.017]

**35.017 Federally Funded Research and Development Centers.**

(a) Policy. (1) This section sets forth Federal policy regarding the establishment, use, review, and termination of Federally Funded Research and Development Centers (FFRDC's) and related sponsoring agreements.

(2) An FFRDC meets some special long-term research or development need which cannot be met as effectively by existing in-house or contractor resources. FFRDC's enable agencies to use private sector resources to accomplish tasks that are integral to the mission and operation of the sponsoring agency. An FFRDC, in order to discharge its responsibilities to the sponsoring agency, has access, beyond that which is common to the normal contractual relationship, to Government and supplier data, including sensitive and proprietary data, and to employees and installations equipment and real property. The FFRDC is required to conduct its business in a manner befitting its special relationship with the Government, to operate in the public interest with objectivity and independence, to be free from organizational conflicts of interest, and to have full disclosure of its affairs to the sponsoring agency. It is not the Government's intent that an FFRDC use its privileged information or access to installations equipment and real property to compete with the private sector. However, an FFRDC may perform work for other than the sponsoring agency under the Economy Act, or other applicable legislation, when the work is not otherwise available from the private sector.

(3) FFRDC's are operated, managed, and/or administered by either a university or consortium of universities, other not-for-profit or nonprofit organization, or an industrial firm, as an autonomous organization or as an identifiable separate operating unit of a parent organization.

(4) Long-term relationships between the Government and FFRDC's are encouraged in order to provide the continuity that will attract high-quality personnel to the FFRDC. This relationship should be of a type to encourage the FFRDC to maintain currency in its field(s) of expertise, maintain its objectivity and independence, preserve its familiarity with the needs of its sponsor(s), and provide a quick response capability.

MITRE

# Your FFRDC: Unique Resource for Impact

## Dedicated to solving complex health and human services problems

Sponsored by all agencies in the Department of Health and Human Services (HHS)

Administered by the Centers for Medicare & Medicaid

- objective insight in conflict-free environment
- long-term strategic partner
- unique vantage point across government
- deep expertise in health - policy – IT
- innovative approach that is interdisciplinary
- broad alliance of private-sector resources

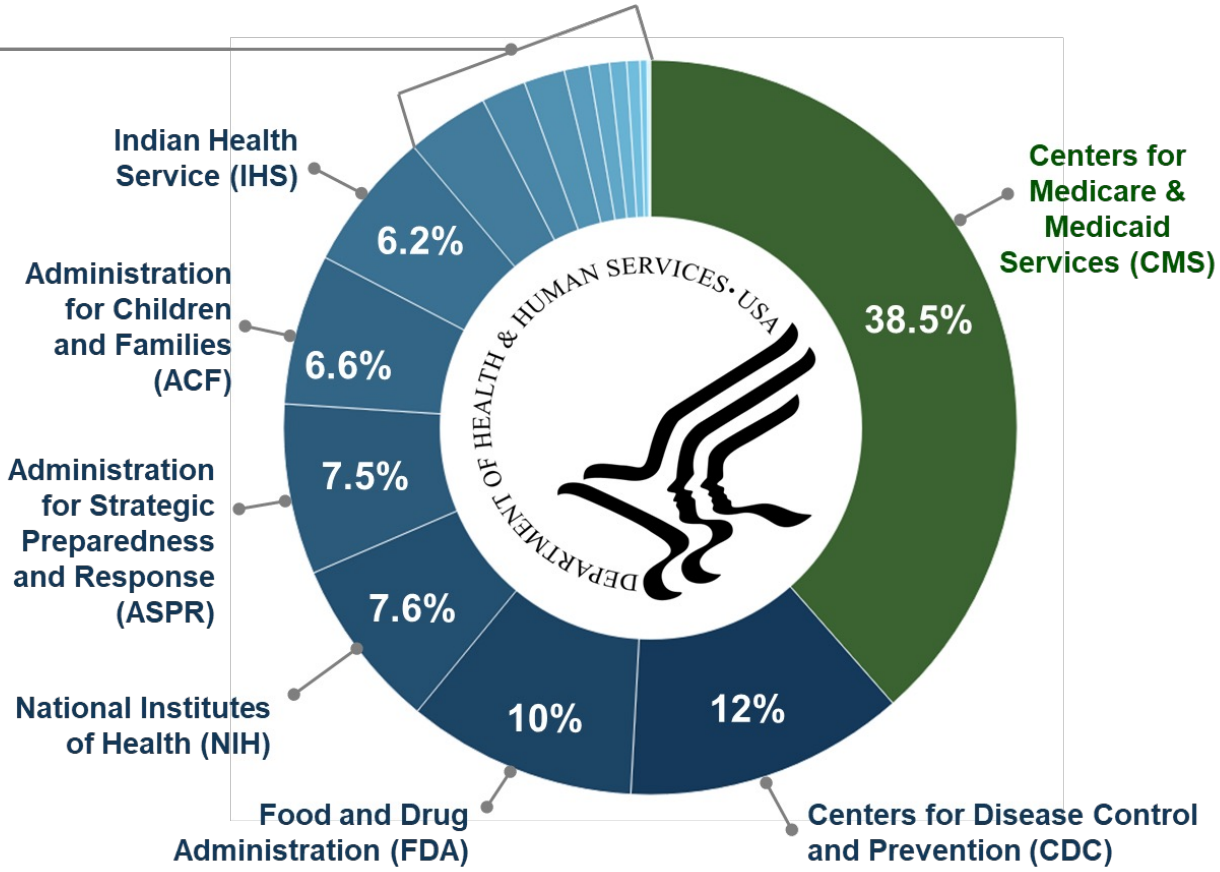
# Connecting Across HHS and the Nation to Deliver Impact

*Percentage of Health FFRDC Work in FY22, by Federal Sponsor*

**3.5% - 0.1%**

- Federal Communications Commission (FCC)
- Health Resources and Services Administration (HRSA)
- Office of the Assistant Secretary for Health (OASH)
- Agency for Healthcare Research and Quality (AHRQ)
- U.S. Army Telemedicine and Advanced Technology Research Center (TATRC)
- Office of the National Coordinator for Health Information Technology (ONC)
- Assistant Secretary for Financial Resources (ASFR)
- Assistant Secretary for Planning and Evaluation (ASPE)
- Office of the Chief Information Officer (OCIO)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

**61.5%** of FFRDC use outside CMS (blue area)




MITRE

*Transforming the way we deliver care begins with realigning our processes*

Targeted configuration of unique high-risk, problem-prone, and high variability workflows

**IMPROVING CARE DELIVERY**

Seamless, consistent, rigorous processes across the field will drive efficiencies to deliver better care

**ENHANCING PATIENT EXPERIENCE**

Enhanced processes in telehealth, patient portal, and digital health applications expands our digital footprint and will enrich patient experiences and provide more seamless access to care

**LEVERAGING DATA TO DRIVE OUTCOMES**

Redesigned processes will improve data capture and data quality fostering innovative analytics to better understand our patient populations and drive improved outcomes

# WRAP: From Challenges to Opportunities

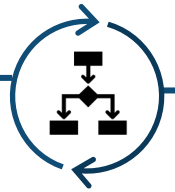
*With every challenge comes an opportunity*

## CHALLENGES

**Mastery of the EHR by the User**
Inefficient and disparate processes can present a challenge to initial and ongoing training and compromise EHR mastery

**Configuring the EHR for the User**
Lack of consistent, rigorous models that do not meet the needs of the user can negatively impact the adoption of the EHR

**Listening to the User in Decision Making**
Various clinical and business partners, dispersed across the country with unique needs, require consistent and deliberate engagement



## OPPORTUNITY

**Using the Models for Configuring, Testing, and Training**
Use of models will be continuous and iterative, lasting through the EHR implementation and optimization

**Leveraging the Models for Vendor Collaboration**
Comprehensive models based on SME engagement will help inform the EHR vendor's configuration efforts

**Empowering the User Via Engagement**
Through consistent and deliberate engagement with user, models will ensure confidence and ownership in the new technology and form a more personalized EHR experience

# IHS Health Information Technology Modernization Preparation for Vendor

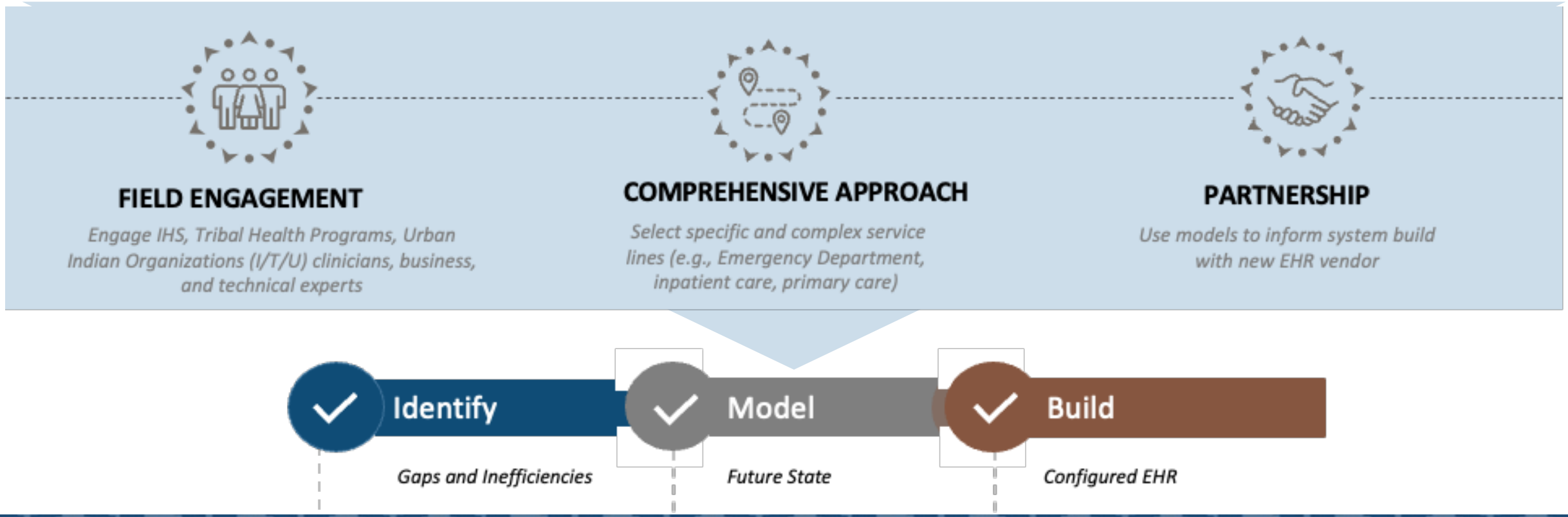
"Too often clinics believe workflow should only be assessed after a vendor product has been selected and just before the health IT is implemented."

- **Agency for Healthcare Research and Quality (AHRQ)**

By understanding workflows and preparing for changes to them throughout the planning and implementation process, a clinic is better prepared for the workflow changes postimplementation.

# Workflow Research Alignment Plan (WRAP) Overview

*WRAP utilizes Business Process Modeling (BPM) to document shared best practice future-state workflows, supporting the configuration and implementation of the new EHR*



# How WRAP Helps HIT Modernization

*WRAP is an ecosystem of tools and methods that allow for…*

**Shareability:**
Models produced can be utilized and localized by another site or across multiple sites within the Indian Health ecosystem

**Standardization:**
Rigorous, thorough models creates a common understanding across Indian Health

**Re-usability:**
Models can be re-used depending on need, location, or uniqueness of site

**Configurability:**
Models provides the foundation to configure, not customize, an EHR software

**Interoperability:**
Models can help "connect the dots" between various systems and platforms

**Extensibility:**
Models are expanded or enhanced through a modular approach, where new functionalities or components can be added incrementally

ULTIMATELY ENHANCING PROVIDER-PATIENT INTERACTIONS

# WRAP Summary

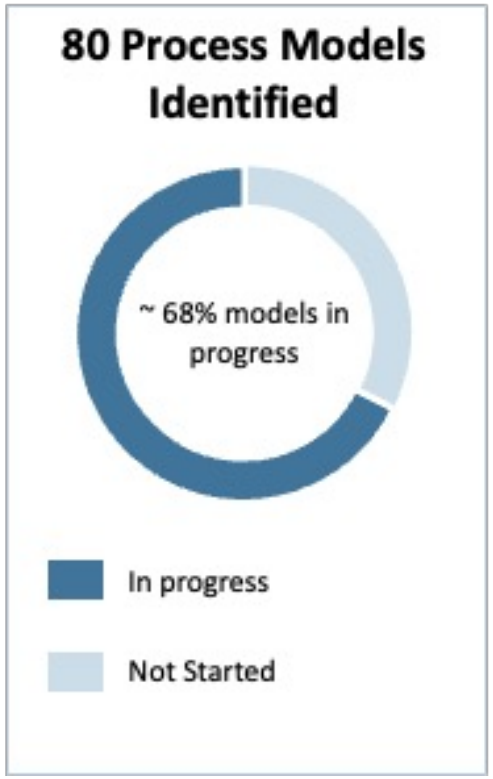
**Phase 1: Environmental Scan** *to collect internal and external information*

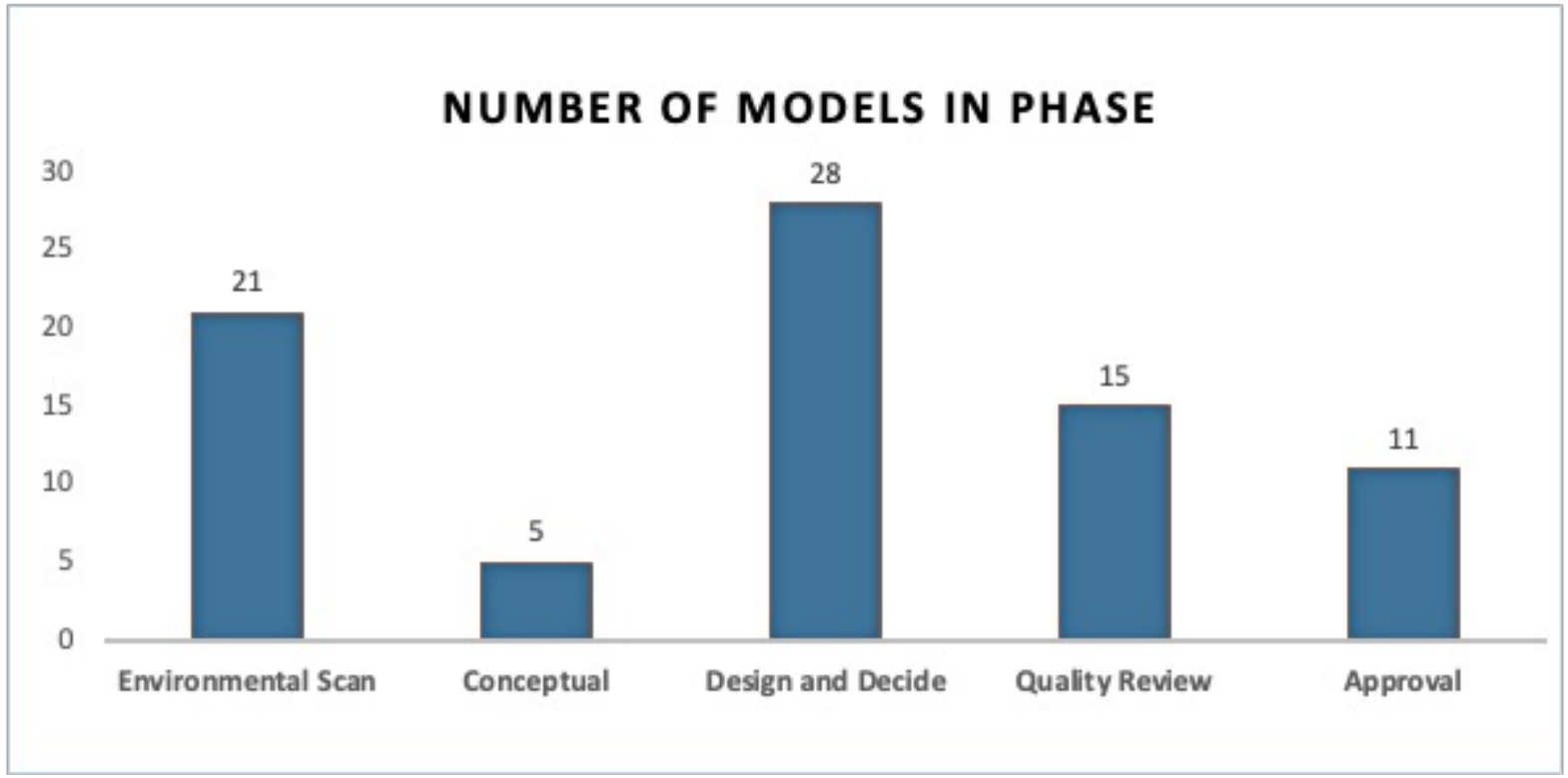
**Phase 2: Conceptual** *to form an overarching understanding of each process model*

**Phase 3: Design and Decide** *to map out the future state models with IHS SMEs*

**Phase 4: Quality Review** *to final check process models for clinical and technical accuracy*

**Phase 5: Approval** *to approve models for Governance review and shared with EHR vendor*



# Prioritization and Categorization of Process Models

*Models are prioritized based on 4 distinct criteria, and categorized into 22 service lines, of which 16 are in progress*

## Criteria for Prioritizing BPM Process Models (via Service Lines)

### 1 Core Functionality

Low — High

*Hospitalization**

- Essential service to the organization?
- Apart of the core business operations?
- Necessary to fulfill mission?

### 2 Uniqueness to IHS

Low — High

*Substance Use Disorder**

- Specialized program or focus area?
- Special configuration required in the EHR?

### 3 Volume

Low — High

*Community Health Aide**

- Number of patients impacted?
- Processes that consume staff time?
- Frequently performed procedures or services?

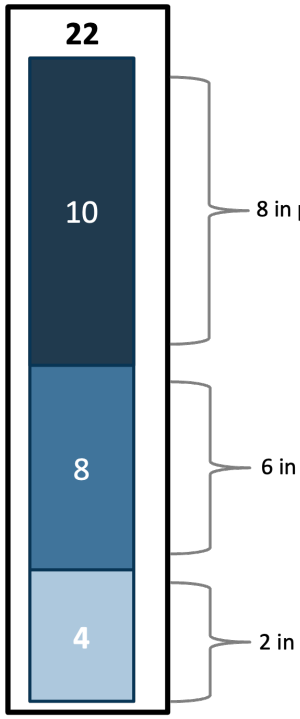
### 4 High Risk

Low — High

*Medication Management**

- Potential for harm to patient or impact to business operations?
- Increase of incidents or errors?
- Complexity of service?

## Total Service Lines




### Care Delivery Services

- **Emergency Department***
- **Hospitalization***
- **Labor Delivery Recovery Postpartum***
- **Primary Care***
- **Residential Treatment Centers***
- Swing Beds
- **Substance Use Disorder***
- **Surgery***
- **Telemedicine***
- Urgent Care

### Support Services

- **Community Health Aide Program***
- **Employee Health***
- Imaging
- **Laboratory***
- **Medication Management and Administration***
- **Nutrition***
- **PAMPI***
- Referral Management

### Business Services

- Population Health
- **Public Health***
- Reporting
- **Revenue Cycle Management***

# List of Models

*The individual status of the 80 models in scope are listed below (Service Line not listed)*

**Phase 1:**
**Environmental Scan**
*to collect internal and external information*

1. Admit to ICU from floor
2. Admit to Surgery from floor
3. Adult Follow up Visit
4. Adult Sick Visit
5. Allergies
6. ICU Medication Management
7. Imaging
8. Immunizations
9. Inpatient Medication Management
10. Medications
11. Pediatric Follow up Visit
12. Pediatric Sick Visit
13. Pediatric Well Child
14. Population Health
15. Procedures
16. Public Health Emergency
17. Referral Management
18. Reporting
19. Surgery Medication Management
20. Swing Beds
21. Transfer to another hospital from floor

**Phase 2:**
**Conceptual**
*to form an overarching understanding of each process model*

1. Blood Bank
2. Day Surgery, Post-op
3. Inpatient Revenue Cycle Management
4. Inpatient Surgery
5. Pathology

**Phase 3:**
**Design and Decide**
*to map out the future state models with IHS SMEs*

1. Administration Medication and Dispensation
2. Ambulatory Medication Management
3. Behavioral Health Aide
4. Chemistry / Hematology
5. Day Surgery, Day of Surgery
6. Day Surgery, Pre-op (Anesthesia)
7. Drug Dependency Unit
8. ED Boarding
9. ED Observation
10. ED Fast Track
11. ED Transition of Care
12. ED Treatment Decision
13. Fulfill Medication Order
14. Hospitalization
15. Labor and Delivery
16. Microbiology
17. OB Triage
18. Outpatient Revenue Cycle Management
19. Public Health Nurse
20. Public Health Threat
21. Postpartum
22. Problem List
23. Process Medication Order
24. Recovery Post Labor and Delivery
25. Refill Authorization Denial
26. Resolve Adverse Drug Event
27. Urgent Care
28. Youth Regional Treatment Centers

**Phase 4:**
**Quality Review**
*to final check process models for clinical and technical accuracy*

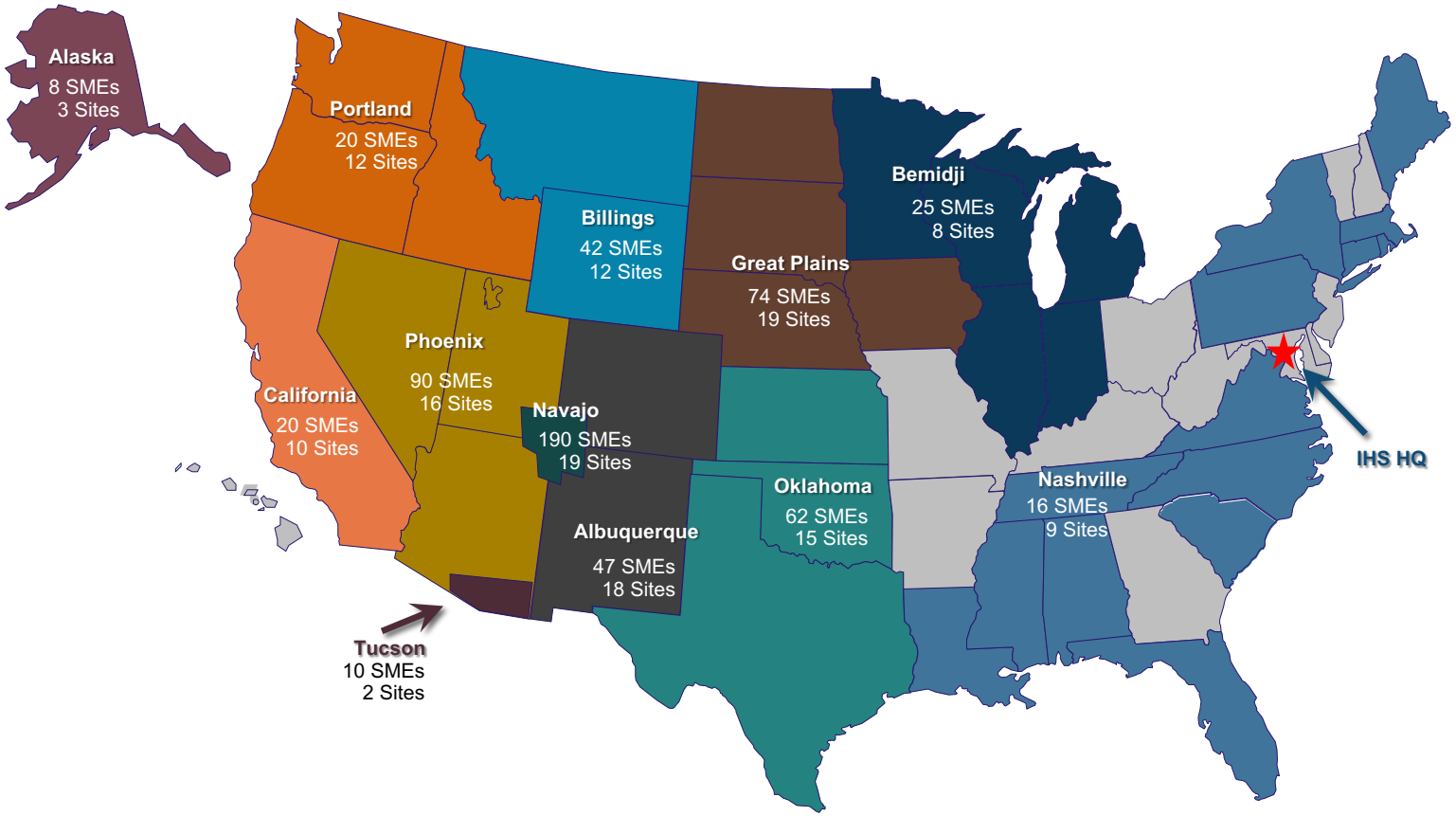
1. Adult New Patient
2. Community Health Representative
3. Day Surgery, Pre-op Clinic
4. Dental Health Aide Therapist
5. Emergency Department Medication Management
6. Emergency Department Point of Care Ultrasound (POCUS)
7. Home Telemedicine
8. Home with Assistance Telemedicine
9. In Clinic Telehealth
10. Inpatient RDN Screening and Consult
11. Medical Management of Inpatient Detoxification
12. Medication Review
13. Remote Telehealth
14. Remote Telehealth with Assistance
15. Substance Use Disorder, Primary Care

**Phase 5:**
**Approval**
*to approve models for Governance review and shared with EHR vendor*

1. Advanced Practice Pharmacist
2. Ambulatory Nutrition
3. Buprenorphine Bridge Program, Emergency Department
4. Community Health Aide
5. Employee Health Exposure – Emergency Department
6. Employee Health Exposure – Primary Care
7. Employee Health Immunizations
8. Employee Health Mass Wellness
9. Group / School Nutrition Event
10. Occupational Health
11. Public Health / Community Nutrition Home Visit

# WRAP by the Numbers

*As of August 1, 2023*




*I/T/U SME engagement throughout the sessions*

**201** WRAP Work - Sessions held between Sept. 2021 and July 2023

**22** Service Lines

**12** Areas Participating (plus IHS HQ)

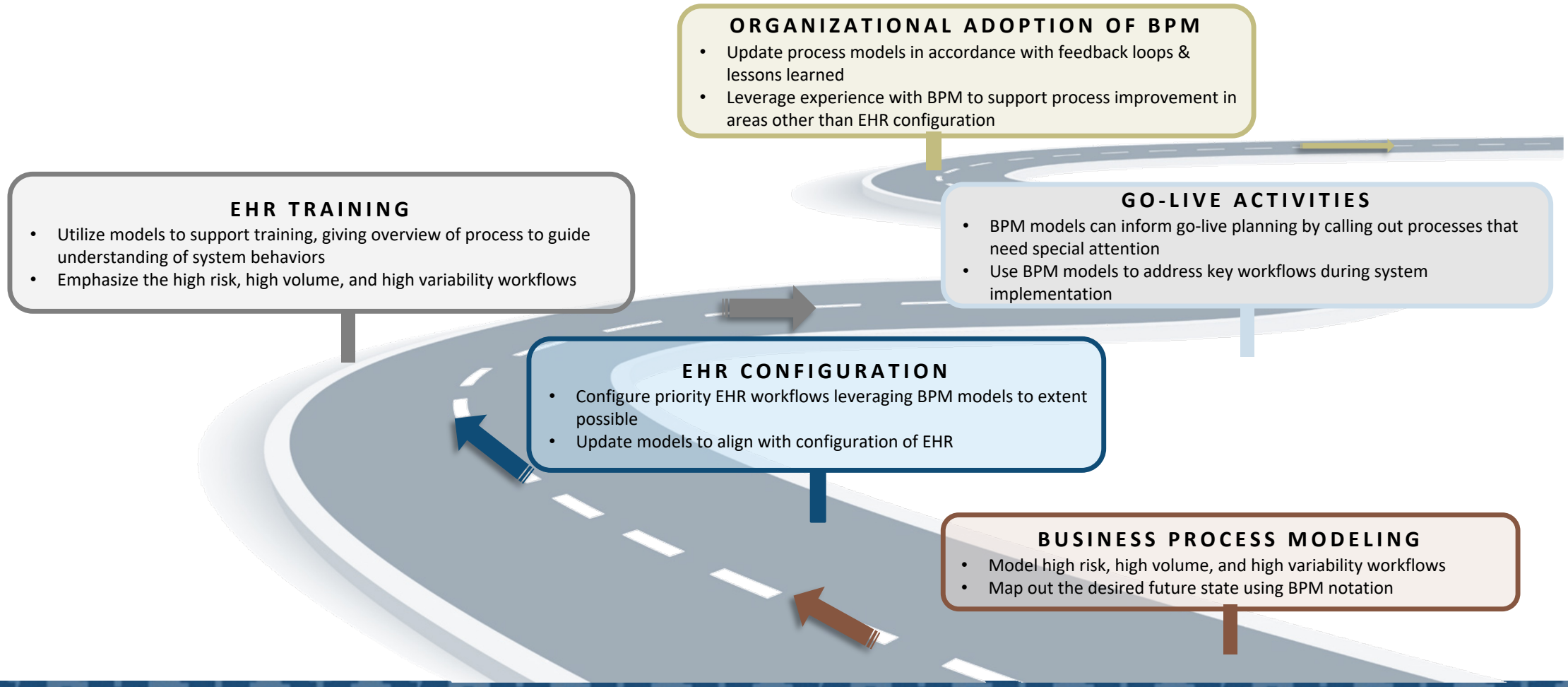
**204** Sites of Care Participating (Station, Center, Clinic, Hospital)

**1300+** Unique SMEs Participating

**5300+** Participant Encounters

# The Path Ahead with WRAP

*WRAP lays the groundwork for configuration, training, implementation, and optimization of the new EHR*



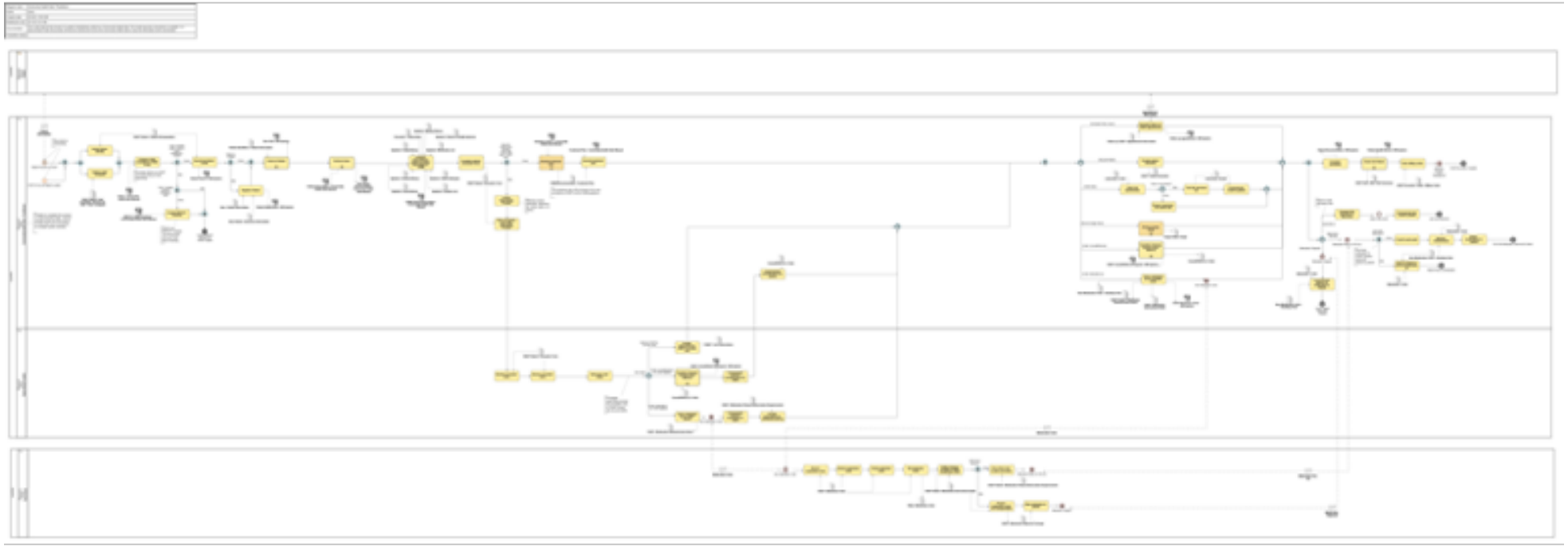
# Community Health Aide Program Models

IHS HEALTH INFORMATION TECHNOLOGY MODERNIZATION

MITRE CORPORATION

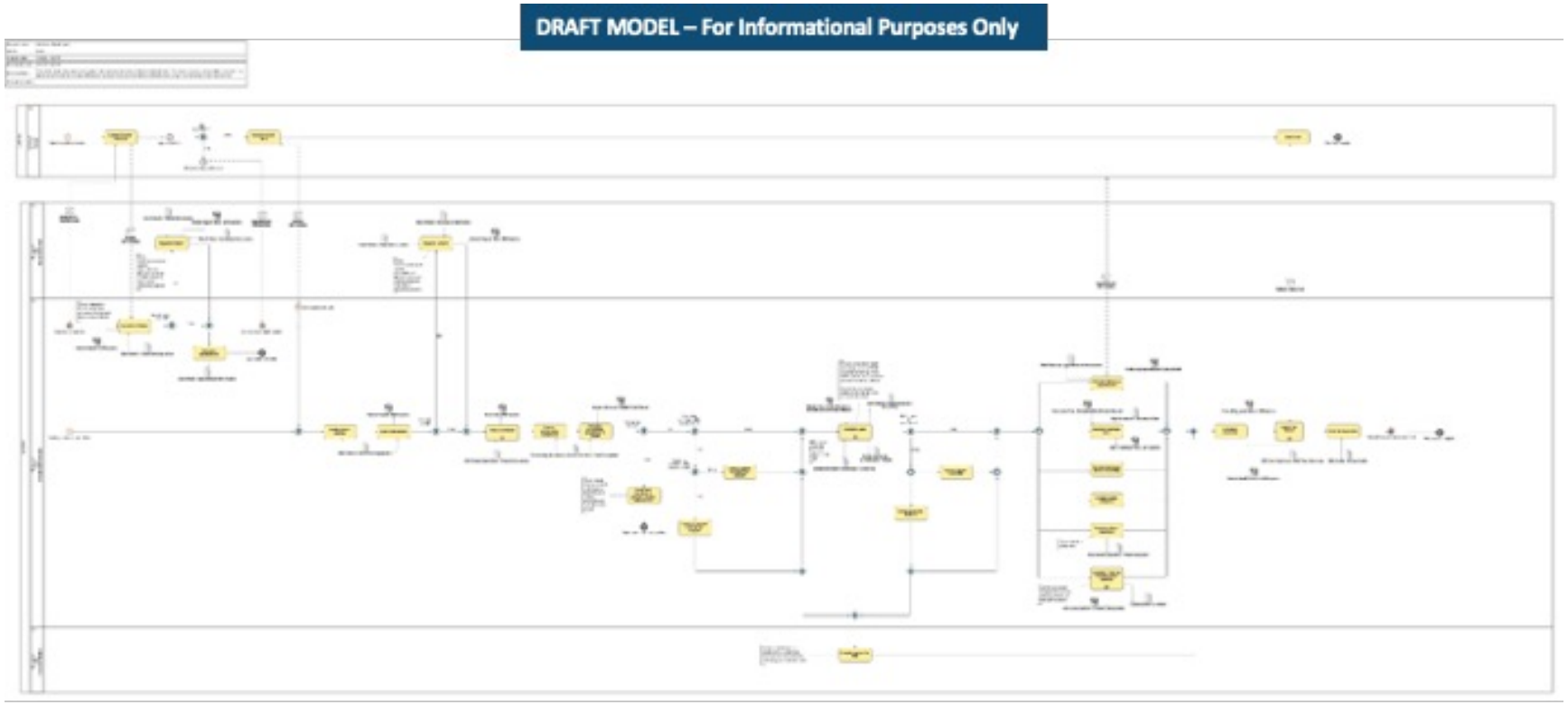
# Community Health Aide / Practitioner (CHA/P)

**DRAFT MODEL – For Informational Purposes Only**



Community Health Aide_Practitioner.png

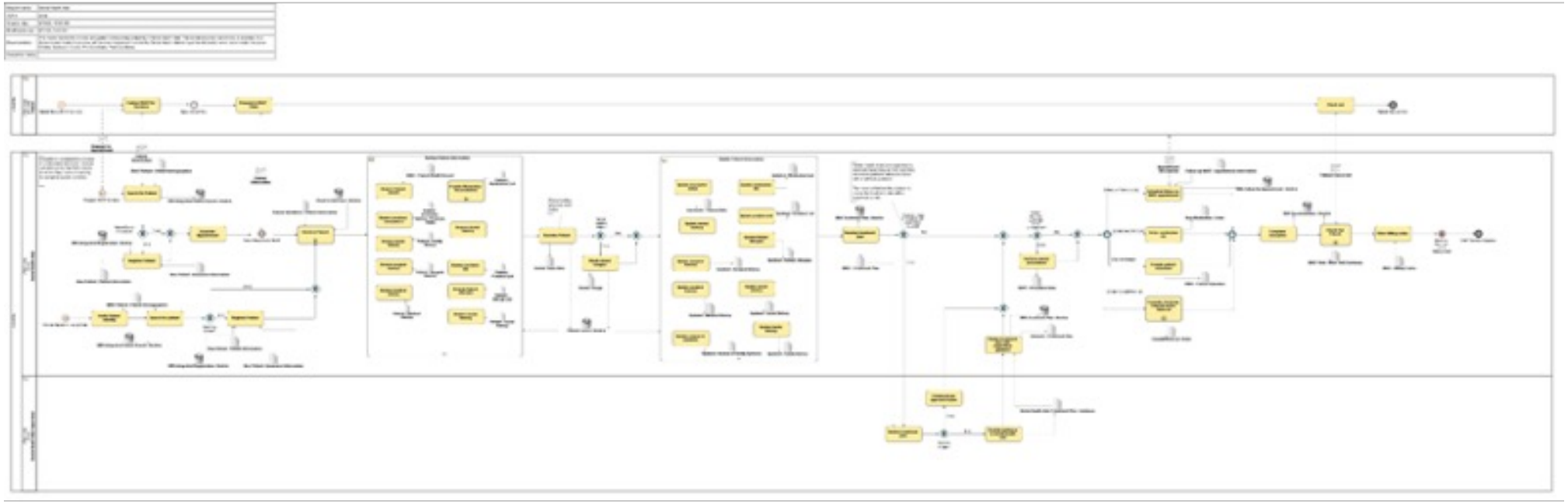
# Behavioral Health Aide (BHA)




Behavioral Health Aide.png

# Dental Health Aide (DHA)

**DRAFT MODEL – For Informational Purposes Only**



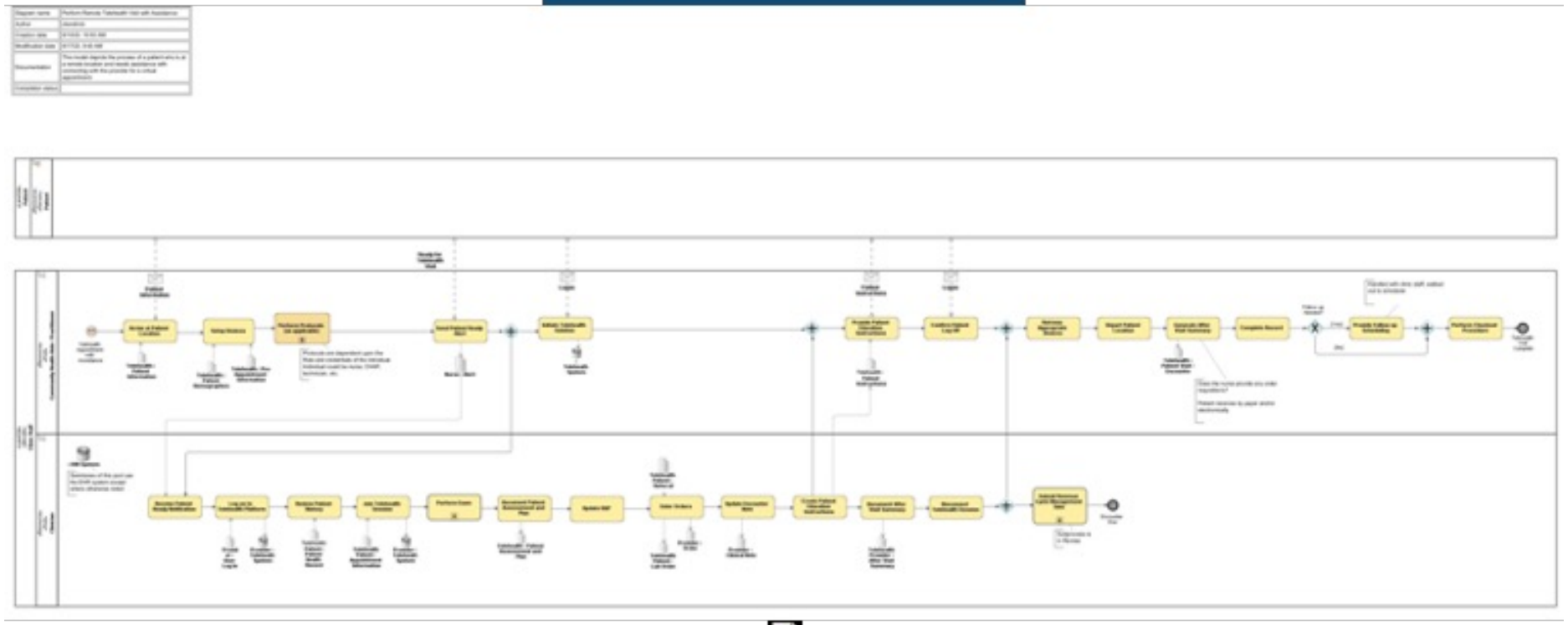
Dental Health Aide.png

# Telehealth: A System of Systems

TELEHEALTH COMBINES WITH A COLLECTION OF OTHER SERVICE LINES TO CREATE A NEW, MORE COMPLEX SYSTEM WHICH OFFERS MORE FUNCTIONALITY, POTENTIAL FOR SCALED IMPACT IN REMOTE PLACES, AND OPPORTUNITIES FOR REVENUE CYCLE MANAGEMENT THAN SIMPLY THE SUM OF THE CONSTITUENT SERVICE LINES

# Telehealth, Remote with Assistance

**DRAFT MODEL – For Informational Purposes Only**



Perform Remote Telehealth Visit with Assistance DRAFT - 7 Aug 2023.png

# Wrap Up/Summary and Move to Questions

# Contact Information

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